jection is *not* intradermal, but intralesional, at a depth of 3 to 7 mm, sometimes more in the case of a thick keloid. The injections should be spaced about 1 cm apart, and only a small amount—about 0.05 ml—injected at each site.

ERNST EPSTEIN, MD
*San Mateo, California*

## Medicaid in California

TO THE EDITOR: I read the article by Beverlee Myers, "Medicaid and the Mainstream: Reassessment in the Context of the Taxpayer Revolt" (West J Med 132:550-561, Jun 1980), with much interest, especially with regard to the various ways the Department of Health Services is going to control the costs of the Medi-Cal program. However, there is no mention of the cost-effectiveness of the proposed program. I also have not come across any reference relating to the administrative costs of running the California Medicaid program (Medi-Cal). I have heard that the administrative costs for the Medi-Cal program run as high as 50 percent (estimated by the Little Hoover Commission). I would like to know if Ms. Myers would like to comment on this.

KELVIN LOH, MD
*Oxnard, California*

* * *

### Ms. Myers Replies

TO THE EDITOR: In response to Dr. Loh's question regarding the cost-effectiveness of the proposed Medi-Cal Restructuring Plan, the Department of Health Services has estimated these reforms would achieve cost savings of approximately 15 percent to 20 percent at the end of a five-year implementation period.

As for Medi-Cal's administrative costs, direct administrative costs are approximately 7.3 percent of total program costs, or about $300 million annually (not counting administrative costs of providers which are included in their payments). A little over half of this administrative cost (55 percent), about $150 million per year, is incurred determining and redetermining eligibility for Medi-Cal benefits; 25 percent is related to fiscal intermediary operations—the process of paying provider claims for services to Medi-Cal beneficiaries; 7 percent is allocated to field services and recovery activities (prior authorization of certain expensive Medi-Cal services, such as inpatient hospitalization, and recovery of funds inappropriately paid by the program); 5 percent is incurred by audits and investigations, and the remaining 8 percent supports all other functions.

The Little Hoover Commission's estimate in 1976 that total administrative costs *may* approach 40 percent went beyond the direct administrative costs discussed above. In addition, it included estimates of provider administrative costs and assumptions about large amounts of program overuse and fraud and abuse by providers and beneficiaries. Such estimates and assumptions are not generally included in the calculation of health insurance administrative costs.

Medi-Cal's 7.3 percent direct administrative cost compares very favorably with those of private health insurance organizations. As reported in the *Statistical Abstract of the United States*—1979, published by the United States Department of Commerce, private health insurance organizations' administrative costs were 12.8 percent of their premium income in 1976. If Blue Cross/Blue Shield is excluded, this figure rises to 18.9 percent.

BEVERLEE A. MYERS, MPH
*Director, California Department of Health Services*
*Sacramento, California*

## County Hospitals, Medi-Cal and Programs of Reform

TO THE EDITOR: I was glad to see the perspective of Beverlee Meyers and Rigby Leighton ("Medicaid and the Mainstream: Reassessment in the Context of the Taxpayer Revolt") in the June 1980 issue. As one who has been a student in and employed by various county hospitals in California for 12 of the last 16 years, primarily serving the Medi-Cal (California's Medicaid program) population, I would like to offer some comments from that perspective.

First, Myers and Leighton speak of legislative and administrative "attempts to limit participation to efficient facilities." They are, I believe, referring to attempts to restrict hospital admissions primarily to county hospitals. County hospitals are strapped with facility, administrative and personnel problems that make them very unlikely candidates for restructuring their medical care delivery systems to become less costly if reorganized in this manner. Medi-Cal at present reimburses a private provider about $10 for a brief office visit. It reimburses hospital outpatient clinics about three times more than this (and emergency rooms are reimbursed even more) for the same level of

service. Shifting care further to county outpatient facilities, the way they are currently structured, might very likely lead to an increase in the cost of care.

The same point can be made about Short-Doyle Medi-Cal, which, for example, may pay a county mental health center $50 for an outpatient visit, regardless of the level of professional training of the provider, while paying a licensed psychologist in the private sector just under $25 to see the same patient. Only Short-Doyle Medi-Cal funded agencies can be paid for the services of nonlicensed personnel. In the private sector, only licensed psychologists and psychiatrists are legally eligible for reimbursement. Here is a specific example in which the current system encourages potentially lower quality at over twice the cost.

Another example of the subtleties of inefficiency is California Assembly Bill 8 (passed in 1979) in which the state reimburses a county for over half of the deficit of their county hospital. This legislation had minimal incentives for efficiency: the larger a hospital's deficit, the greater the handout. This kind of reward for inefficiency on one side (public sector) with increasing control of overpayments on the other side (private) makes me think that when cleaning its own house, the state is more concerned about supporting counties than it is about costs of medical care. This may be a worthwhile goal, but it should be addressed as such and not disguised as Medi-Cal reform.

It is obvious from the Meyers-Leighton article that the annual expenditures per eligible enrollee in Medi-Cal has grown at a rate significantly less than of inflation, and that the main reason for the large increases in the Medi-Cal budget has been to expand the number of people covered (and this may be reasonable in post-Proposition 13 times, in order to shift the tax burden away from the counties to the state). In that context, the current cost of the Medi-Cal program may not be unreasonable. I doubt very much, however, given the constraints of county health care systems, that any alternative based on their exclusive use, given the same number of people, is going to be less expensive than one based on achieving a competitive balance between the public and private sectors.

I agree with the authors about many of the problems of Medi-Cal, and I agree with their underlying emphasis on prepayment and financial incentives for efficiency. Other potential ideas for cost savings that were not addressed in the article include health education for appropriate use of services, copayment by beneficiaries, decreasing use of emergency rooms, increasing alternatives to skilled nursing facilities, providing mainstream care through established health maintenance organizations and decreasing administrative costs. Overall, when considering that health care is now properly viewed as a right, I feel Californians have gotten a lot for their money through Medi-Cal. Before returning to a more two-tier health care system, I would want to see some documentation and careful study showing that it would, in fact, decrease costs without lowering quality, and that the goals of saving county hospitals and reforming Medi-Cal are separated where need be.

JONATHAN E. RODNICK, MD
*Santa Rosa, California*